MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03516

3532 Item 9, Filmed80 4-25-55 at

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) Since 11/2/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 27 Harman Avenue

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Hillary (Last) AHALT

4. DATE OF DEATH: (Month) April (Day) 15 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: January 31, 1883

9. AGE last birthday 72 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timekeeper

10B. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D. Ahalt

14. MOTHER'S MAIDEN NAME: Harriet Willard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42.0.1
IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis with hypertension — more than 1½ years
DUE TO (C) ___

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. — more than 1½ years

19A. DATE OF OPERATION: ___
19B. MAJOR FINDINGS OF OPERATION ___
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ___
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ___

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ___
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ___

22. I hereby certify that I attended the deceased from 12/7/53, to 4/14/55 that I last saw the deceased alive on April 14, 1955, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

SIGNATURE: Martin Gross, M.D. ADDRESS: Martin Gross M.D. Sykesville, Md. DATE SIGNED: 4/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: APRIL 19-55
NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETRY
LOCATION (City, town, or county) (State): HAGERSTOWN Md

DATE REC'D BY LOCAL REGISTRAR: April 16, 1955
REGISTRAR'S SIGNATURE: C. Harry Weer
24. FUNERAL DIRECTOR: C M SOLER & SONS ADDRESS: HAG. Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03517

3533

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — STATE Maryland
CITY (If outside corporate limits, write RURAL OR TOWN (give nearest town)) Gettysburg — LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Gettysburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural, give location) Broadway

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) CLAUDE (Last) BILLMYER

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	W	Aug 25-1873	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Station Agent	WM RR	Maryland	USA

13. FATHER'S NAME: Reuben Billmyer

14. MOTHER'S MAIDEN NAME: Caroline Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	705-10-5149	James I Billmyer, 39 W 67th St New York City NY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
422.1 Immediate cause	(a) Cerebral Hemorrhage	4 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arterio sclerotic C-V disease	years.
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from June 19 53, to April 28 19 55, that I last saw the deceased alive on April 29, 19 55, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
James I. Marsh	M.D.	Westminster Md	Apr 28/1955

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 30-1955	Mt Vieyo	Union Bridge

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 29 1955	Francis M. Smyth	D D Hartzler & Sons	New Windsor Md

03518

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3534

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (In this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARTHA - (Middle) NORMA (Last) CARR
4. DATE OF DEATH: (Month) April (Day) 13 (Year) 19 55
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow
8. DATE OF BIRTH: aug 8-1876
9. AGE last birthday: 78 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Work.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Basil Gardner
14. MOTHER'S MAIDEN NAME: Rachel Price
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: no
17. INFORMANT AND ADDRESS: Mrs Geo Lippy - Manchester Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) Arteriosclerotic Heart Disease	5 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congestive Heart Failure	1 day
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to April 12, 1955, that I last saw the deceased alive on April 12, 1955, and that death occurred at 8. A m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
W. H. Foard | M.D. | Manchester Md | 4-12-55

23. BURIAL, CREMATION REMOVAL (Specify): Buried | DATE THEREOF: April 15/55 | NAME OF CEMETERY OR CREMATORY: Bucklerville | LOCATION (City, town, or county) (State): Bulto Co Md

DATE REC'D BY LOCAL REG. Apr. 12-55 | REGISTRAR'S SIGNATURE: Mrs. W.P. Penner | 24. FUNERAL DIRECTOR: Edw Clipton | ADDRESS: Hampstead Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

3535

03519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithers
LENGTH OF STAY (In this place) 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Gaithers
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Ellen (Last) Cooper

4. DATE OF DEATH (Month) April (Day) 26 (Year) 1955

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH: Sept. 8, 1929

9. AGE last birthday: 25 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Gilbert Hudgins

14. MOTHER'S MAIDEN NAME: Elizabeth R. Ray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT & ADDRESS: Charles C. Cooper - Gaithers, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

900.0
Immediate cause (a) Fractured Skull — Interval between onset and death: 30 min.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Fall down stairway
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Home

21c. (City or town) Gaithers (County) Carroll (State) Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 4/26/55 1:45 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? She fell down stairway

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Sharrah M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 4/26/55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried
DATE THEREOF 4-29-55
NAME OF CEMETERY OR ~~CREMATORY~~ Lorraine Park
LOCATION (City, town, or county) (State) Baltimore 7, Md.

DATE REC'D BY LOCAL REG. April 27, 1955
REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Luther H. Haight
ADDRESS Lyksville, Md.

03520

MARYLAND STATE DEPARTMENT OF HEALTH

3536

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown; LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print): (First) Wirt (Middle) Patterson (Last) Crapster

4. DATE OF DEATH: (Month) April (Day) 8, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Feb. 1, 1926

9. AGE last birthday: 29 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Crapster

14. MOTHER'S MAIDEN NAME: Ellen Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW2

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. Walter Crapster, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
974X Immediate cause	(a) Strangulation	few Min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Suicide by Hanging	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Manic Depressive Psychosis — 8 yrs.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN): Taneytown (COUNTY): Carroll (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): April 8, 1955 10 a.m. INJURY OCCURRED While at work ☐ Not while at work ☑ HOW DID INJURY occur? Hanged self by rope to rafter.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

R. S. McVaugh M.D. Taneytown, Md. April 8, 1955

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: April 11, 1955 | NAME OF CEMETERY OR CREMATORY: Reformed Cemetery | LOCATION (City, town, or county) (State): Taneytown, Maryland

DATE REC'D BY LOCAL REG.: April 9, 1955 | REGISTRAR'S SIGNATURE: Ethel M Mehring | 24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03521

3537

CERTIFICATE OF DEATH

Reg. Dist. No. 71

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X LINWOOD
LENGTH OF STAY (in this place) Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linwood
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) A (Last) CRUMBACKER

4. DATE OF DEATH: (Month) APRIL (Day) 2 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Aug 14 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Purina Feeds

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Crumbacker

14. MOTHER'S MAIDEN NAME: Ella Koons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: 497-01-1000

17. INFORMANT & ADDRESS: Emma Crumbacker Linwood Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 153 X (a) DUE TO Cancerous of liver & Intestine

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ..., 19 52, to April 2, 19 55, that I last saw the deceased alive on April 2, 19 55, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

SIGNATURE J. N. Legg (Degree or title) M D ADDRESS Union Bridge DATE SIGNED 4-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF April 5-1955 NAME OF CEMETERY OR CREMATORY Lutheran LOCATION (City, town, or county) Uniontown (State) Md

DATE REC'D BY LOCAL REGISTRAR April 4, 1955 REGISTRAR'S SIGNATURE Margaret K. England

24. FUNERAL DIRECTOR D. D. Hartzler & Sons ADDRESS New Windsor Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

3538

2411 N. Charles Street, Baltimore

03522

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Mt. Airy
LENGTH OF STAY (in this place) 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Newport Hill - Rt 2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Mt. Airy X
STREET ADDRESS (If rural, give location) Route 2 - Newport Hill

3. NAME OF DECEASED (Type or Print): (First) Simon — (Middle) — (Last) Davis

4. DATE OF DEATH: (Month) April (Day) 6 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: March 11, 1869

9. AGE last birthday: 86 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Bunion Davis

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Mrs. Sam Davis - Route 2 - Mt. Airy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4.50.0

Immediate cause (a) Generalized Arteriosclerosis — Interval between onset and death: several years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to April, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 1.40 A. m., from the causes and on the date stated above.

SIGNATURE: W.B. Culwell — (Degree or title) MD — ADDRESS: Mt. Airy, Md. — DATE SIGNED: April 6, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 4-9-1955 — NAME OF CEMETERY OR CREMATORY: Mt. Olive — LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REG. 4-8-1955 — REGISTRAR'S SIGNATURE: Robert R. Hewitt, Dpty. — 24. FUNERAL DIRECTOR: C.M. Waltz — ADDRESS: Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03523

3539

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, Film 180 4-29-55 et

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 3yrs.12days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City 3V31-4
STREET ADDRESS (If rural give location): 800 Cator Ave. /Armacost Nursing Home ✓

3. NAME OF DECEASED: (Type or Print) (First) AGNES (Middle) PLACIDE (Last) DEAN

4. DATE OF DEATH: (Month) April (Day) 20 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Unknown

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Doory

14. MOTHER'S MAIDEN NAME: Anna Conley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

5-5X

Immediate cause (a) Inflammation of the Pancreas — Interval Between Onset And Death: About 4 wks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cholecystitis, chronic — Unknown

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — Approx. 8 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-15 ,1955 , to 4-20 , 1955, that I last saw the deceased alive on 4-20 , 1955 , and that death occurred at 10:03 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or Title): Walter H. Jonas M.D.

ADDRESS: Springfield State Hospital

DATE SIGNED: April 20, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF: 4/22/55

NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL CEM.

LOCATION (City, town, or county) (State): BALTO. MD

DATE REC'D BY LOCAL REGISTRAR: 4-21-55

REGISTRAR'S SIGNATURE: A W Redmond

24. FUNERAL DIRECTOR: JOHN A. MORAN

ADDRESS: 3000 E. BALTO. ST

SI Pa Returns

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03524

3540 CERTIFICATE OF DEATH Reg. Dist. No. ... .

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield, Maryland
STREET ADDRESS (If rural give location) 129 S. 4th Street

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Ann (Last) Dix

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-14-1918

9. AGE Last birthday: 37 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Crab Picker

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Somerset County, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Harry Sample

14. MOTHER'S MAIDEN NAME: Moreal Collins

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Howard Dix - 129 S. 4th Street, Crisfield, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause 002X (a) Far advanced bilateral pulmonary TB, cavitation. October '54

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7- ,1955 , to 4-13- , 1955 , that I last saw the deceased alive on 4-13-55, 19 , and that death occurred at 5:25 p.m. , from the causes and on the date stated above.

SIGNATURE (Degree or title) T.F. Vestal, M.D ADDRESS Henryton, Maryland DATE SIGNED 4-13-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Apr 18 1955 NAME OF CEMETERY OR CREMATORY Lawsonia LOCATION (City, town, or county) (State) Crisfield Somerset Co Md

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE Albert R. Swanbrow

24. FUNERAL DIRECTOR Charles H. Howard ADDRESS Manor Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03525

Item 8, Film G181 5-9-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Westminster — LENGTH OF STAY (in this place) 87
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Rural) RFD-4

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster (Rural) X
STREET ADDRESS (If rural give location) R F D. 4

3. NAME OF DECEASED: (Type or Print) (First) Agnes (Middle) Virginia (Last) Dull
4. DATE OF DEATH: (Month) April (Day) 18 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: June 16 - 1867
9. AGE last birthday: 87 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Coats
14. MOTHER'S MAIDEN NAME: Liddie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Wilbur Dull Westminster 4 Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Arteriosclerotic Heart Disease — 5 yrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Arteriosclerosis — 5 yrs.
DUE TO
(c)
420.0

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 26, 1955, to April 18, 1955, that I last saw the deceased alive on April 17, 1955, and that death occurred at 6:40 AM from the causes and on the date stated above.

SIGNATURE: W. H. Foard — (Degree or title) M. D. — ADDRESS: Manchester Md — DATE SIGNED: 4-18-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Apr. 21, 1955 — NAME OF CEMETERY OR CREMATORY: Westminster Cemetery — LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: 4-18-55 — REGISTRAR'S SIGNATURE: Harriet Miller

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

VS. A15

03526

3542

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X SYKESVILLE
LENGTH OF STAY (in this place) 4 1/2 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS LIBERTY ROAD - ROUTE 2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 6 1/2 ST = SYKESVILLE
STREET ADDRESS (If rural, give location) ROUTE # 3

3. NAME OF DECEASED (Type or Print): (First) MINNIE (Middle) ANN (Last) GRIFFITH
4. DATE OF DEATH: (Month) APRIL (Day) 25 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: NOV. 18-1901
9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): TASWELL - VA.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM COLE
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: MR HOWARD GRIFFITH — ROUTE #2 SYKESVILLE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1 1X **Immediate cause** (a) CARCINOMA OF BLADDER C

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) METASTASIS TO LUMBAR VERTEBRA — 3 YEARS
(c) HYPERTENSIVE C.V. DISEASE - MODERATE — 5 YEARS

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from FEB 1, 19 55, to APRIL 28, 19 55, that I last saw the deceased alive on APRIL 28, 19 55, and that death occurred at 6:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Howard E. Wheeler MD 3601 Clifton Rd - Baltimore Md - 4-28-55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 4-30-1955
NAME OF CEMETERY ~~OR CREMATORY~~ Wesley Freedom
LOCATION (City, town, or county) (State) CARROLL Co. Md.

DATE REC'D BY LOCAL REG. April 30, 1955
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS C. M. Watts, Winfield. Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03527

CERTIFICATE OF DEATH

3543 Reg. Dist. No. . . .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 38 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton, Maryland X
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) (Last) Hawkins

4. DATE OF DEATH: (Month) 4 (Day) 20 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 1871

9. AGE last birthday: 84 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Handy Man

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William Hawkins

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Mary Sweete - Bel Alton, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 002X
(a) Far advanced bilateral pulmonary tuberculosis
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) . . . . .
DUE TO
(c)

Interval Between Onset And Death: Dec. 1954

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-13- ,1955, to 4-20- , 1955, that I last saw the deceased alive on 4-20- , 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) T. F. Nesbit, M.D
ADDRESS Henryton, Maryland
DATE SIGNED 4-20-55

23. BURIAL, CREMATION, REMOVAL: (Specify) Burial
DATE THEREOF 4/23/55
NAME OF CEMETERY OR CREMATORY St Ignatius
LOCATION (City, town, or county) (State) Chapel Point md
DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Albert A. Smallwood
24. FUNERAL DIRECTOR Orchard Funeral Home
ADDRESS Laplata md

VS. A15

03528

3528

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (In this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 58 E. Main

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — 27
STREET ADDRESS (If rural, give location) 58 E. Main

3. NAME OF DECEASED (Type or Print): (First) ESTELLA (Middle) S. (Last) HOFFE
4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 5 1902
9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilcox Co. Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James Lumbard Roland
14. MOTHER'S MAIDEN NAME: Mary Frances Jordan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 254-24-8911
17. INFORMANT: Charles J. Elkins Humbert apts. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerotic C V Disease — years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James T. Woods Deputy Med. Examiner Westminster Md 4/9/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: April 12, 1955
NAME OF CEMETERY OR CREMATORY: Pleasant Hill Cemetery
LOCATION (City, town, or county) (State): Sycamore Georgia

DATE REC'D BY LOCAL REG. 4-9-55
REGISTRAR'S SIGNATURE: Harold Mills
24. FUNERAL DIRECTOR: Wentworth Home Westminster, Md.
ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03529

CERTIFICATE OF DEATH

3548

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 85 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. 4

3. NAME OF DECEASED: (Type or Print) (First) HENRY (Middle) LEWIS (Last) HOSFELD

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min.
M	W	Married	Dec. 25 1869	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: own farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George A. Hosfeld
14. MOTHER'S MAIDEN NAME: Mary Mahaley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mrs Cora Hosfeld R.D. 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X
Immediate cause (a) Acute Cardiac Decompensation — Interval Between Onset and Death: 4 hrs
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Cardio-Renal Vascular disease — 5 yrs
DUE TO
(c) Arteriosclerosis — 6 yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Prostate — 5 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4 1955 to 4-4-55, 1955, that I last saw the deceased alive on 4-4-55, 1955, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Chas K Fenby MD ADDRESS Westminster Md DATE SIGNED 4-5-55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 6 1955	Leister Cemetery	Westminster Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-6-55	Hamil Fuller	A. Bankard & Son	Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03530

3529

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 127 E. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural give location): 127 E. Green St.

3. NAME OF DECEASED: (First) Joshua (Middle) Leland (Last) Jordan

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 20, 1897

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Westminster, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Scott I. Jordan

14. MOTHER'S MAIDEN NAME: Henerietta Boring

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
(If Yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 212-01-8693

17. INFORMANT & ADDRESS: Margaret B. Jordan Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: Few minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertension Coronary Sclerosis & Angina — Dec 1954

DUE TO (c) Cerebral Hemorrhage — March 1955

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1954, to April 22, 1955, that I last saw the deceased alive on April 22, 1955, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wilbur Reicher — ADDRESS: Westminster Md — DATE SIGNED: 4-23-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Apr. 25, 1955

NAME OF CEMETERY OR CREMATORY: Westminster Cemetery

LOCATION (City, town, or county) (State): Westminster Maryland

DATE REC'D BY LOCAL REGISTRAR: April 23 1955

REGISTRAR'S SIGNATURE: Lonnie M. Dougis

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03531

3545

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

1. PLACE OF DEATH:
   COUNTY Carroll — MARYLAND
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
   LENGTH OF STAY (in this place) 16yrs.4days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE Maryland — COUNTY
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
   STREET ADDRESS (If rural give location) 2312 E. Fayette Street

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) LOUIS (Last) KANE

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 25, 1892

9. AGE last birthday: 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10B. KIND OF BUSINESS OR INDUSTRY: E. J. Codd

11. BIRTHPLACE (State or foreign country): Maryland, Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael T. Kane

14. MOTHER'S MAIDEN NAME: Mary A. Flaharty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

OO ix

IMMEDIATE CAUSE (A) Tuberculosis of lung, far-advanced — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH Schizophrenia — 33 years

19A. IF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8- , 1955 to 4-22 , 1955, that I last saw the deceased alive on 4-22 , 1955, and that death occurred at 12:10PM, from the causes and on the date stated above.

SIGNATURE Walter A. Sommerfeldt M.D. — ADDRESS Springfield State Hospital — DATE SIGNED 4-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Apr. 26, 1955 — NAME OF CEMETERY OR CREMATORY: New Cathedral Cem. — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR: 4-25-55 — REGISTRAR'S SIGNATURE: H. W. Hedrick

24. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. — ADDRESS: 2601-3-5 E. Madison St.

3546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 32

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sykesville X
STREET ADDRESS (If rural, give location) Route 3 Wolfe Rock Rd.

3. NAME OF DECEASED: (First) Mildred (Middle) M. E. (Last) Leach Kelly (Type or Print)
4. DATE OF DEATH (Month) April (Day) 15 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 8-28-11
9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Claude Leach
14. MOTHER'S MAIDEN NAME: Rebecca Fox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

Immediate cause (a) 4711.X Hanging by the neck

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. psychotic depressive reaction

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY SS Hospital
21c. (City or town) Sykesville (County) Carroll (State) Md
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Branch M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 4/15/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 4-19-55
NAME OF CEMETERY OR CREMATORY Mt Hope
LOCATION (City, town, or county) Woodbine, Md. (State)

DATE REC'D BY LOCAL REG. April 17, 1955
REGISTRAR'S SIGNATURE C. Harry Tilden
24. FUNERAL DIRECTOR Luther H. Haight
ADDRESS Sykesville, Md.

VS. A15A - 5 - 53

03533

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3547

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY Carroll MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Manchester LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS OD	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print)	(First) FLORENCE	(Middle) CONSTANCE	(Last) LAUER	4. DATE OF DEATH	(Month) April	(Day) 2,	(Year) 1955
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
Female	White	Widowed	NOVEMBER 16, 1878	76 yrs.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE MARYLAND.	USA

13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
? CONSTANCE		?	?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO		none	MR HARRY L. CLEAVER 3028 KENYON AVE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4:20 Immediate cause	(a) Coronary Thrombosis	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	15 yrs
	(c) Arteriosclerosis	15 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to April 2, 1955, that I last saw the deceased alive on 3-24, 1955, and that death occurred at 10:50 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M.C. Porterfield	M.D	Hampstead Md	4/2/55

23. BURIAL, CREMATION (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	APRIL 5, 1955	Greenmount Cemetery	Baltimore, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-5-55	L. W. Hedrick	H. SANDER & SONS, INC.	Baltimore, Maryland George Sander

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03534

3548

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Myersville
STREET ADDRESS (If rural give location): Route # 2

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
IRA	ELLSWORTH	LEWIS	April	26	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	5-16-74	80 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Lewis	Elizabeth Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
Immediate cause 413.1	(a) DUE TO	Myocardial Infarction	Hours
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	Cellulitis with lymphangitis of leg	3 weeks
	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain dis., with psychotic reaction. — About 5 yrs.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-5- ....,19 55, to ..4-26....., 19 55., that I last saw the deceased alive on ....4-26., 19..55 and that death occurred at 10:40 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Edmund L Nusbaum	Springfield State Hospital	4-26-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-29-55	Mt. Bethel	Garfield, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 27, 1955	C Harry Thew	Gladhill Co.	Middletown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03535

3530

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
LENGTH OF STAY (in this place): 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 101 John St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural give location): 101 John St.

3. NAME OF DECEASED: (First) Mary (Middle) ---- (Last) Locascio
4. DATE OF DEATH: (Month) April (Day) 5 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Feb. 14, 1880
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Victor Gagliano
14. MOTHER'S MAIDEN NAME: Liboria Purporia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: - - - - - - - - -
17. INFORMANT & ADDRESS: Vincent Locascio Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 442 (a) Uremia Coma — Interval Between Onset And Death: 2 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cardio-renal-vascular disease — 3 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from April 5, 1946, to 4-5, 1955, that I last saw the deceased alive on 4-5, 1955, and that death occurred at 12:00 P. M., from the causes and on the date stated above.

SIGNATURE (Degree or title): C. K. Billingslea M.D
ADDRESS: Westminster, Md.
DATE SIGNED: 4-6-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Apr. 8, 1955
NAME OF CEMETERY OR CREMATORY: St. John's Catholic
LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: 4-6-55
REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: John R. Byers
ADDRESS: Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03536

3549

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 3y10m20days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 618 Chestnut Hill Avenue

3. NAME OF DECEASED (Type or Print): (First) Amelia (Middle) Susan (Last) Maglidt

4. DATE OF DEATH: (Month) 4 (Day) 9 (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5 - 1 - 1881
9. AGE last birthday: 73 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pensylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Heilman
14. MOTHER'S MAIDEN NAME: Amelia Sauter

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no, or unk.) no — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unkn.
17. INFORMANT & ADDRESS: William Maglidt, 618 Chestnut Hill ave. Balto.18.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Cerebral hemorrhage	2 weeks
ANTECEDENT CAUSE (S) — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (B) Hypertensive cardiovascular disease	years
	DUE TO (C)	
II SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	Chron.brain syndrome assoc.with senile disease with psychotic reactions	years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8- , 19 55 to 4-9- , 19 55 that I last saw the deceased alive on 4-9- , 19 55, and that death occurred at 5:55 P M, from the causes and on the date stated above.

SIGNATURE Edmund Lustbaum M.D. — ADDRESS Springfield State Hospital — DATE SIGNED 4-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Apl 12-55
NAME OF CEMETERY OR CREMATORY: Greenmount
LOCATION (City, town, or county) (State): York Penna

DATE REC'D BY LOCAL REGISTRAR: 4-16-55
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: Bertram D. Kile
ADDRESS: 2224 N Charles St.

3550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 035374

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) since 5/15/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1535 E. Baltimore Street

3. NAME OF DECEASED: (Type or Print) George (First) R. (Middle) Manly (Last)

4. DATE OF DEATH: (Month) Apr. (Day) 22 (Year) 1955

5. SEX male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed | 8. DATE OF BIRTH. 8-25-9[illegible] | 9. AGE last birthday 69 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): odd jobs
10B. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Manley
14. MOTHER'S MAIDEN NAME: Rose Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes-Navy
(If Yes, give war or dates of service) 4-14-17/5-6-20
16. SOCIAL SECURITY NO. 214-03-9677
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 411X (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 18 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with alcohol intoxication, with psychotic reaction — about 4 years

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15-53, 19__, to 4-22-, 19 55 that I last saw the deceased alive on 4-22-, 1955, and that death occurred at 11.35 PM. from the causes and on the date stated above.

SIGNATURE Florian Nadolski — ADDRESS M.D Sykesville, Md — DATE SIGNED April 23, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Apr 26/55 — NAME OF CEMETERY OR CREMATORY Parkwood Mem — LOCATION (City or town, or county) (State) Baltimore

DATE REC'D BY LOCAL REGISTRAR 4-25-55 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Philip Henry Sons — ADDRESS 2024 Eutaw St

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (13538)

1 3551 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (In this place) 7 yrs. 3 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) Helping Hand Mission ✓

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) COGAN (Last) MARTIN

4. DATE OF DEATH: (Month) April (Day) 5, (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single | 8. DATE OF BIRTH: 3-25-1900 | 9. AGE last birthday 54 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer | 10B. KIND OF BUSINESS OR INDUSTRY: Masonry | 11. BIRTHPLACE (State or foreign country): Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick F. Martih | 14. MOTHER'S MAIDEN NAME: Mary Cogan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) None | (If Yes, give war or dates of service) - | 16. SOCIAL SECURITY NO. Unk - | 17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 422.1 (A) Cardio-vascular disease — Years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (322.1) (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic alcoholism with deterioration. — Years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10 , 1955, to 4-5- , 1955, that I last saw the deceased alive on 4-5 , 1955, and that death occurred at 10:20 AM, from the causes and on the date stated above.

SIGNATURE Walter J. Sonnenfeldt, M. D. ADDRESS Springfield State Hospital DATE SIGNED 4/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-9-55 | NAME OF CEMETERY OR CREMATORY Elkins | LOCATION (City, town, or county) (State) Elkins W. Va.

DATE REC'D BY LOCAL REGISTRAR April 6, 1955 | REGISTRAR'S SIGNATURE C. Henry Lee | 24 FUNERAL DIRECTOR H. E. Rumer. ADDRESS Elkins, W. Va.

03539

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3552

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (in this place) 69 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Taneytown Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster R.D. #4
STREET ADDRESS (If rural, give location) Old Taneytown Road

3. NAME OF DECEASED (Type or Print): (First) LUTHER (Middle) CLEVELAND (Last) MARTIN

4. DATE OF DEATH: (Month) April (Day) 27 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Oct. 29, 1885

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker

10b. KIND OF BUSINESS OR INDUSTRY: Piston Ring factory

11. BIRTHPLACE (State or foreign country): Carrollton, Carroll. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Martin

14. MOTHER'S MAIDEN NAME: Mary A. Sharp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-01-1953

17. INFORMANT AND ADDRESS: Mrs L. Martin, Westminster Md. RD#4

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 " 4 "

Immediate cause (a) Metastatic Carcinoma to liver — Interval between onset and death: 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma rectum — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec. 4, 1953

19b. MAJOR FINDINGS OF OPERATION: Carcinoma rectum with metastases to liver

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30, 1953, to April 27, 1955, that I last saw the deceased alive on April 27 55, and that death occurred at 9:52 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Julius Chepko M.D. Westminster Md 4/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 30/55 — NAME OF CEMETERY OR CREMATORY: Lesters Cemetery — LOCATION (City, town, or county) (State): Rural, Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: April 28 55 — REGISTRAR'S SIGNATURE: Louise M. Orwig

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr., Westminster Md.

VS. A15

03540

MARYLAND 3553 **STATE DEPARTMETT OF HEALTH**

CERTIFICATE OF DEATH

Reg. Dist. No. 24

Item 2, Film G181, 5/12/55 fcy

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 5yrs. 8days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City, 417 N. Charles St.
STREET ADDRESS (If rural, give location) Church Home Hosp. Broadway & Fairmount Ave

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Rebecca (Last) Mills
4. DATE OF DEATH: (Month) 4 (Day) 27 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9-16-1864
9. AGE last birthday: 90 yrs. If under: Months. 1 year Days Hours 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress -- Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Hidgesville, West Va.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John Startzman
14. MOTHER'S MAIDEN NAME: Miranda A. Snodgrass
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --- (If year, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary occlusion	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	10 yrs.
	(c) Senile psychosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: ---- 19b. MAJOR FINDINGS OF OPERATION: ----- 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---- PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ---- (CITY OR TOWN) ---- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 1-16- , 1952, to 4-27- , 1955, that I last saw the deceased alive on 4-27- , 1955, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE, M. N. Mastin, M. D. (Degree or title) — ADDRESS — DATE SIGNED

M N Mastin MD — Springfield State Hosp. - Sykesville, Md. — 4-27-55

23. BURIAL, CREMATION, REMOVAL (Specify): burial — DATE: 5-2-55 — NAME OF CEMETERY OR CREMATORY: Mt Carmel — LOCATION (City, town, or county) (State): Baltimore

DATE REC'D BY LOCAL REG.: 5-2-55 — REGISTRAR'S SIGNATURE: C.W. Kennick — 24. FUNERAL DIRECTOR: Fred. A. Cole — ADDRESS: 1913 W. Baltimore St.

55

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1 03541

3554

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Fairboro
LENGTH OF STAY (in this place) 28 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairboro
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Monath

4. DATE OF DEATH: (Month) April (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: July 31 1862

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Cobbler

10b. KIND OF BUSINESS OR INDUSTRY: Self.

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Monath

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: E. J. Monath, Linboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchio-pneumonia — Interval Between Onset And Death: 1wk

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerotic Heart — 5 yrs

DUE TO

(c) Senile

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7 ....,1948, to 4-21 ....,1955, that I last saw the deceased alive on 4/20 ....,1955, and that death occurred at 10.55 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W H Foard M D Manchester, Md 4-21-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4/23/55 NAME OF CEMETERY OR CREMATORY Fairboro LOCATION (City, town, or county) Fairboro (State) Carroll Md

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR Apr. 22-55 Mrs. H. P. Donner

24. FUNERAL DIRECTOR H. C. Seifert Son ADDRESS Glen Rock, Pa.
H. C. Seifert

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03542

3555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 2month17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (11) 3401-4
STREET ADDRESS (If rural give location) 409 Central Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) JOSEPH (Middle) MICHAEL (Last) MOULDS

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced
8. DATE OF BIRTH: June 29, 1897
9. AGE last birthday: 57 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sail Maker
10B. KIND OF BUSINESS OR INDUSTRY: Robinson Bros.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS. Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	162X		
ANTECEDENT CAUSE (S):	(A) DUE TO	Cancer of the lung	6 months +
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO		
	(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with new growth, with intra-cranial neoplasm, with psychotic reaction. — About 6 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION (metastatis - primary Ca. of the lung)
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-11, 1955 to 4-28, 1955, that I last saw the deceased alive on 4-27, 1955, and that death occurred at 3:40AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 4/30/55
NAME OF CEMETERY OR CREMATORY St.Mary's, Hampden
LOCATION (City, town, or county) (State) 3900 Roland Ave, Md.

DATE REC'D BY LOCAL REGISTRAR April 27, 1955
REGISTRAR'S SIGNATURE A. C. Hedrick
24. FUNERAL DIRECTOR Austin E. Donovan
ADDRESS 3818 Roland Ave

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03543

355 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 26

Item 8, Filr G180 4-26-55 et

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
LENGTH OF STAY (in this place) 59 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Willow Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
STREET ADDRESS (If rural, give location) 15 Willow Avenue

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) FRANKLIN (Last) MYERS

4. DATE OF DEATH: (Month) April (Day) 16 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1886 - 2 - 18 - 1886

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Westminster Shoe Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Albin D. Myers

14. MOTHER'S MAIDEN NAME: Catherine Starner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-05-7187

17. INFORMANT & ADDRESS: Bertha Myers 15 Willow Avenue Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 331X
Immediate cause (a) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days 3 1/2
DUE TO
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) None
TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 4, 1955 to Apr. 16, 1955 that I last saw the deceased alive on Apr. 16, 1955, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

SIGNATURE [signature] M.D. (DEGREE OR TITLE) ADDRESS Westminster DATE SIGNED 4/18/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF April 19, 1955 NAME OF CEMETERY OR CREMATORY Krider's Cemetery LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. 4-18-55 REGISTRAR'S SIGNATURE Harriet Miller **24. FUNERAL DIRECTOR** H Bankard & Son ADDRESS Westminster, Md.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03544

3557

CERTIFICATE OF DEATH

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X New Windsor
LENGTH OF STAY (In this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor X
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
LEWIS	EDWARD	PATTERSON	APRIL	13	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
M	C	M	Oct 12-1895	59 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Laura E Patterson Sr	Mary Bell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	no	212-03-5381	Lydia J Patterson, New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

169X Immediate cause (a) Carcinoma of Lung — 1 yr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Ca of Left Lung	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 54, to Apr 13, 1955, that I last saw the deceased alive on Apr 12, 1955, and that death occurred at 8:45 AM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James J Marsh	M.D	Westminster Md	4/15/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/16/55	Mt Olive	Carroll Co. Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr 15 55	Emma L Bemiller	D D Hartzler & Sons	New Windsor

MARYLAND

03545

STATE DEPARTMETT OF HEALTH

3558

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll (Myers District) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Union Mills
LENGTH OF STAY (in this place) 2 yrs. 8 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadow View Convalescent Home Westminster, Md. R. D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna. COUNTY Adams County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Littlestown
STREET ADDRESS (If rural, give location) East King Street

3. NAME OF DECEASED (Type or Print): (First) Flora (Middle) Belle (Last) Reindollar

4. DATE OF DEATH: (Month) 4/29/55 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 3/1/1865

9. AGE last birthday: 90 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework, Housewife, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Harner

14. MOTHER'S MAIDEN NAME: Rebecca Fink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: J. Ray Reindollar Lumber St., Littlestown, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) chronic myocardial disease — Interval between onset and death: 10 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1955 to April 30, 1955, that I last saw the deceased alive on April 29, 1955, and that death occurred at 11:55 m., from the causes and on the date stated above.

SIGNATURE Boyd B. Cooper (Degree or title) M. D. ADDRESS Littlestown Pa DATE SIGNED April 30, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 5/2/55 | NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | LOCATION (City, town, or county) (State) Littlestown, Adams Co., Pa.

DATE REC'D BY LOCAL REG. 4-30-55 | REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR J. W. Littlestown ADDRESS Littlestown, Pa.
Per R. A. Little

03546

MARYLAND — **STATE DEPARTMETT OF HEALTH**

3559

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 9mos. 19days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 3319 Dudley Ave. ✓

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) (Last) Rezek

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-24-1885

9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Czech.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Broz

14. MOTHER'S MAIDEN NAME: Anna (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset and Death: 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION: ----

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ----

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ----

(CITY OR TOWN) (COUNTY) (STATE): ----

TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 1-15-19 55, to 4-13-, 19 55., that I last saw the deceased alive on 4-12-, 19 55., and that death occurred at 4:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): M. N. Martin, M.D.

ADDRESS: Springfield State Hosp. - Sykesville, Md.

DATE SIGNED: 4-13-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4-16-55

NAME OF CEMETERY OR CREMATORY: Oak Hill

LOCATION (City, town, or county) (State): Balto. Md

DATE REC'D BY LOCAL REG.: April 14, 1955

REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: F. Evans

ADDRESS: 900 Chester St. Balto. Md.

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03547

3560

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, LENGTH OF STAY (in this place) 42 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 03X
STREET ADDRESS (If rural give location) c/O Ernie Barth, Route 99, Ellicott City

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Keyes (Last) Ridgely

4. DATE OF DEATH: (Month) 4 (Day) 2 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH: 8 - 11 - 94

9. AGE last birthday 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Gaither

14. MOTHER'S MAIDEN NAME: Mary Keyes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No. unkn.

17. INFORMANT & ADDRESS: Ernest Ridgely c/O Ernie Barth, Route 99

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE	(A) Pleural Effusion, both lungs	5 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (B) Cancer of the right breast	2 years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	C.B.S. ass.with cerebral arterisclero-sis with psychotic reactions	years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-19- , 1955, to 4-1- , 1955, that I last saw the deceased alive on 4-2- , 1955, and that death occurred at 7- P.M, from the causes and on the date stated above.

SIGNATURE Edmund Leathan M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-3-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4-6-55

NAME OF CEMETERY OR ~~CREMATORY~~ St John's

LOCATION (City, town, or county) (State) Ellicott City, Md.

DATE REC'D BY LOCAL REGISTRAR April 4, 1955

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR [illegible] ADDRESS Catonsville

03548

MARYLAND — **STATE DEPARTMETT OF HEALTH**

3561

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY: Carroll — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville — LENGTH OF STAY (In this place): 6mo. 11 days — HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital — MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland 21-C 2 — STREET ADDRESS (If rural, give location): 315 Franklin Street

3. NAME OF DECEASED (Type or Print): (First) Marie (Middle) Catherine (Last) Russell

4. DATE OF DEATH: (Month) (Day) 21 (Year) 1955

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 2-2-1883

9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk-

10b. KIND OF BUSINESS OR INDUSTRY: Unk-

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Alien

13. FATHER'S NAME: Antone Lerdollt

14. MOTHER'S MAIDEN NAME: Margaret Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk-

17. INFORMANT AND ADDRESS: Anthony J. Russell - Cumb. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44 X

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive arteriosclerotic cardiovascular disease — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. due to Cerebral arterioscleroticis — several mo.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11 ., 19 54., to 4-24 ., 1955., that I last saw the deceased alive on 4-24 ., 19 55., and that death occurred at 1:15 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter H. Sommerfeldt M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: 4/29/55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE: 4/27/55 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: 4-25-55 — REGISTRAR'S SIGNATURE: C. Harry Eckert

24. FUNERAL DIRECTOR: John Hafer — ADDRESS: Cumb., Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3531 CERTIFICATE OF DEATH

03549
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Webster Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
STREET ADDRESS (If rural give location) 14 Webster Street

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) Russell (Last) Schweigart
4. DATE OF DEATH: (Month) April (Day) 28 (Year) 19 55
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 10, 1875
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: City Bldgs.
11. BIRTHPLACE (State or foreign country): Westminster, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Louis Schweigart
14. MOTHER'S MAIDEN NAME: Emily Mourer
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ------
16. SOCIAL SECURITY No.: 216-07-2935
17. INFORMANT & ADDRESS: Mrs. Agnes B. Schweigart Westminster, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio vascular disease — Interval Between Onset And Death: 1 yr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) arteriosclerosis — about 1945

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 15, 1949, to Apr. 28, 1955, that I last saw the deceased alive on Apr. 28, 1955, and that death occurred at 7.25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. E. Billingslea M.D. ADDRESS Westminster, Md. DATE SIGNED 4-29-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Apr. 30, 1955
NAME OF CEMETERY [illegible] Westminster
LOCATION (City, town, or county) (State) Westminster Md.

DATE REC'D BY LOCAL REGISTRAR Apr 29 1955
REGISTRAR'S SIGNATURE Louis N. Smith

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03550

3562

CERTIFICATE OF DEATH

Reg. Dist. No. ... .

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Mills
LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Meadow View Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural give location): 144 Penna. Ave.

3. NAME OF DECEASED: (Type or Print) (First) Laura (Middle) Genevieve (Last) Shipley

4. DATE OF DEATH: (Month) April (Day) 23 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. 11, 1859

9. AGE last birthday: 96 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Lambert

14. MOTHER'S MAIDEN NAME: Cordelia Ann Glass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: - - - - - - -

17. INFORMANT & ADDRESS: Miss Lillian Shipley Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 24 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) arteriosclerosis — 10 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to April 23, 1955, that I last saw the deceased alive on Apr 23, 1955, and that death occurred at 12:35 PM, from the causes and on the date stated above.

SIGNATURE: Julius Chopko (Degree or title) M. D. ADDRESS: 130 E. Green. Westminster, Md. DATE SIGNED: 4/23/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Apr. 25, 1955 | NAME OF CEMETERY OR CREMATORY: Westminster Cemetery | LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: April 23. 1955 | REGISTRAR'S SIGNATURE: Louise M. Enuigh

24. FUNERAL DIRECTOR: John R. Byers | ADDRESS: Westminster, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3563 03551

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH. COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 5 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Field State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY T
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md
STREET ADDRESS (If rural give location) 1629 Patapsco St

3. NAME OF DECEASED: (Type or Print) (First) Christina (Middle) (Last) Stepanuk

4. DATE OF DEATH (Month) Apr (Day) 3 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH: Sept 15 1892 | 9. AGE last birthday 62 yrs. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Longwork | 11. BIRTHPLACE (State or foreign country): Russia | 12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Mike Kozak | 14. MOTHER'S MAIDEN NAME: Olga Koyanch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. Unk | 17. INFORMANT & ADDRESS: Oscar Stepanuk

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSE (B) DUE TO: Acute Arterio Sclerosis — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO: Hypertension — 5 yr

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 2 1949 to Apr 3, 1955, that I last saw the deceased alive on Apr 3, 1955 and that death occurred at 3-30 P.M. from the causes and on the date stated above.

SIGNATURE M. D. Madison MD | ADDRESS Sykesville Md | DATE SIGNED Apr 3 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-6-55 | NAME OF CEMETERY OR CREMATORY Russian Orthodox | LOCATION (City, town, or county) Elkridge, Howard | (State) Md.

DATE REC'D BY LOCAL REGISTRAR Apr 4, 1955 | REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR John F. Kinney Inc. | ADDRESS 915 Light St. Balto.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3564 **CERTIFICATE OF DEATH** 03552

Reg. Dist. No. 6

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. 4 Reese

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
STREET ADDRESS (If rural give location) R. 4 Reese

3. NAME OF DECEASED: (Type or Print) (First) Addie (Middle) Belle (Last) Taylor

4. DATE OF DEATH: (Month) April (Day) 15 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Jan. 25, 1875

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Houne Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles T. Blizzard

14. MOTHER'S MAIDEN NAME: Catherine Brown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - -

16. SOCIAL SECURITY No.: - - - - -

17. INFORMANT & ADDRESS: Mrs. Hilda Green R 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 3 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Arteriosclerosis 2nd + Hypertension — 1 week

DUE TO (c) Myocarditis - chronic — years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-30 ..., 19.., to 4-15 ..., 19.., that I last saw the deceased alive on 4-15 ..., 19.., and that death occurred at 2 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) James D Sadtler M.D. ADDRESS Reisterstown Md DATE SIGNED 4-15-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF April 18, 1955 — NAME OF CEMETERY OR CREMATORY St. Paul's — LOCATION (City, town, or county) (State) Arcadia Balto Co. Md.

DATE REC'D BY LOCAL REGISTRAR 4-16-55 — REGISTRAR'S SIGNATURE Harold Smith

24. FUNERAL DIRECTOR John R. Byers — ADDRESS Westminster, Md.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03553

3565

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct (age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Rural Westminster R6

LENGTH OF STAY (in this place): life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Bird Hill

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster R 6

STREET ADDRESS (If rural give location): Bird Hill

3. NAME OF DECEASED: (Type or Print) (First) Martico (Middle) (Last) Welch

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 2, 1867

9. AGE last birthday: 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Martico Welch

14. MOTHER'S MAIDEN NAME: Sarah Ann Ogg

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Samuel M. Welch R. 6 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval Between Onset And Death: 10 days.

DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.

(b) Generalized Arteriosclerotic Cardiovascular Renal Disease

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23, 1955, to 4/4, 1955, that I last saw the deceased alive on 4/3, 1955, and that death occurred at 10:5 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Allen Morton M.D. Westminster Md 4/4/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Apr. 6, 1955 — NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery — LOCATION (City, town, or county) (State): Smallwood, Maryland

DATE REC'D BY LOCAL REGISTRAR: 4-5-55 — REGISTRAR'S SIGNATURE: Harriet Mullen

24. FUNERAL DIRECTOR ADDRESS: John R. Byers Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03554

3566

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 Park Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location) 104 Park Ave

3. NAME OF DECEASED: (Type or Print) (First) Rudolph (Middle) Belschen (Last) Wink

4. DATE OF DEATH: (Month) 4 (Day) 15 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1/27/91

9. AGE last birthday: 64 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Funeral Director (own)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Wink

14. MOTHER'S MAIDEN NAME: Annie Josephine Belschen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Freda B. Wink Manchester Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Adenocarcinoma — Interval Between Onset And Death: 2 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Ileum
DUE TO (c) Widespread metatasis

1552 X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to April 15, 1955, that I last saw the deceased alive on 4-13, 1955, and that death occurred at 3 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) W H Howard MD — ADDRESS Manchester Md — DATE SIGNED 4-15-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4/17/55 — NAME OF CEMETERY OR CREMATORY Manchester Cem. — LOCATION (City, town, or county) (State) Manchester Carroll Md

DATE REC'D BY LOCAL REGISTRAR 4-17-55 — REGISTRAR'S SIGNATURE Mrs. H.P.S. Denner — 24. FUNERAL DIRECTOR J. J. Kernan — ADDRESS McSherrystown Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03555

3567

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X TOWN Rural--Westminster

LENGTH OF STAY (In this place) life

HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Westminster X

STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) W. (Last) Wolf

4. DATE OF DEATH: (Month) April (Day) 7, (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	9-20-1877	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
farmer	owner	Maryland	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Peter Wolf	Christina ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Peter Wolf, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

421.4

Immediate cause (a) Chr. Valvular Heart Disease deconpensation

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic nephritis (Anuria)

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 51, to 4/7/, 1955., that I last saw the deceased alive on 4/7/, 1955., and that death occurred at 1:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Wm. E. Martin M.D. Randallstown Md 4/9/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	4-10-1955	Trinity Lutheran	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
4-8-55	Harriet Miller	C. M. Waltz, Winfield, Maryland

3563 03556

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Manchester road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) NINA (Middle) V. G (Last) WOOD

4. DATE OF DEATH (Month) April (Day) 9 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 1868 | 9. AGE Last birthday: about 87 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Halifax, Canada | 12. CITIZEN OF WHAT COUNTRY? Canadian

13. FATHER'S NAME: John Taylor Wood | 14. MOTHER'S MAIDEN NAME: Lola Mackubin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT & ADDRESS: Miss Lola Wood Westminster Rural

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arteriosclerotic C-V disease — Years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J Mann M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ DATE SIGNED 4/9/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF April 12 1955 | NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery | LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. 4-11-55 | REGISTRAR'S SIGNATURE Harriet Mellor | 24. FUNERAL DIRECTOR Baile and Son | ADDRESS Westminster, Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03557

3569

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 29yr. 3mo. 24days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3Y01-4
STREET ADDRESS (If rural give location) 703 N. Gilmor Street ✓

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) WHITRIDGE (Last) WYNN

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 1, 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph R. Wynn

14. MOTHER'S MAIDEN NAME: Emily Gould

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) Myocardial infarction	minutes
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Coronary occlusion	N
904.9	DUE TO (c) Arteriosclerotic cardio-vascular disease	years.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Fracture of left hip	45 days
	Manic depressive reaction, manic phase, plus alcoholism.	39 years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1955, to 4-26, 1955, that I last saw the deceased alive on 4-26, 1955, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-26-55

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF 4-26-55 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) 1217 St Paul St. Balto.

DATE REC'D BY LOCAL REGISTRAR April 27, 1955 REGISTRAR'S SIGNATURE C. Henry Wise

24. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 St Paul St. Balto. Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3570

03558
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 1month9days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Baltimore 1
STREET ADDRESS (If rural, give location): 721 W. Lexington Street

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROSE ZILINSKA	April 30 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	1-1-1873	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Poland	Unknown

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Martera ?	Agnes Agorta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No —	Unk -	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Bronchopneumonia	Hours
DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	Cardio-vascular renal disease	Unknown
DUE TO			
	(c)	Arteriosclerosis	Unknown

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic react. Unknown

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
	Hospital	Sykesville Carroll Maryland

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
4 19 1955 8:50 P.M.		Fell out of bed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: James J. Thomas M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED: 5/2/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	5-4-55		1217 St Paul St. Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 4, 1955	C. Harry Wurl	Wm. Cook Inc.	1217 St Paul St Balto Md.

VS. A15A - 5 - 53